

EXAMINATION QUESTIONNAIRE (Please print)

Client Name: _____ Date: _____
 Date of Birth: _____ Sex: _____ Height: _____ Weight: _____
 Referring Case Manager's Name: _____ Phone: _____
 CSB: _____ Case Manager's email address: _____
 Is Client COOPERATIVE or UNCOOPERATIVE for dental services? (Please circle one) _____
 Residential Provider: _____ Contact: _____ Phone: _____
 Residential Address: _____ City: _____ Zip: _____
 Guardian/LAR/AR: _____ Phone: _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past years? Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician? Yes No
If so, what is the condition being treated _____
4. The name and address of my physician(s) is _____

5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
If so, what was the illness or problem? _____

6. Are you taking any medicine(s) including non-prescription medicine? Yes No
If so, what medicine(s) are you taking? _____

7. Do you have or have you had any of the following diseases or problems?
 - a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease.... Yes No
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
 1. Do you have chest pain upon exertion?..... Yes No
 2. Are you ever short of breath after mild exercise or when lying down?..... Yes No
 3. Do your ankles swell?..... Yes No
 4. Do you have inborn heart defects?..... Yes No
 5. Do you have a cardiac pacemaker?..... Yes No
 - c. Allergy..... Yes No
 - d. Sinus trouble..... Yes No
 - e. Asthma or hay fever..... Yes No
 - f. Fainting spells or seizures..... Yes No
 - h. Diabetes..... Yes No
 - i. Hepatitis, jaundice, or liver disease..... Yes No
 - j. AIDS or HIV infection..... Yes No
 - k. Thyroid problems..... Yes No
 - l. Respiratory problems, emphysema, bronchitis, etc..... Yes No
 - m. Arthritis or painful swollen joints..... Yes No
 - n. Stomach ulcer or hyperacidity..... Yes No
 - o. Kidney trouble..... Yes No
 - p. Tuberculosis..... Yes No
 - q. Persistent cough or cough that produces blood..... Yes No
 - r. Persistent swollen glands in neck..... Yes No
 - s. Low blood pressure..... Yes No

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| | | |
|--|-----|----|
| t. Sexually transmitted disease..... | Yes | No |
| u. Epilepsy or other neurological disease..... | Yes | No |
| v. Problems with mental health..... | Yes | No |
| w. Cancer..... | Yes | No |
| x. Problems of the immune system..... | Yes | No |
| 8. Have you had abnormal bleeding? | Yes | No |
| a. Have you ever required a blood transfusion:..... | Yes | No |
| 9. Do you have any blood disorder such as anemia? | Yes | No |
| 10. Have you ever had any treatment for a tumor or growth? | Yes | No |
| 11. Are you allergic or have you had a reaction to: | | |
| a. local anesthetics..... | Yes | No |
| b. Penicillin or other antibiotics..... | Yes | No |
| c. Sulfa drugs..... | Yes | No |
| d. Barbiturates, sedatives or sleeping pills..... | Yes | No |
| e. Aspirin..... | Yes | No |
| f. Iodine..... | Yes | No |
| g. Codeine or other narcotics..... | Yes | No |
| h. Other..... | Yes | No |
| 12. Have you had any serious trouble associated with any previous dental treatment? | Yes | No |
| If so, explain: _____ | | |
| 13. Do you have any disease, condition, or problem not listed above that you think I should know about? | Yes | No |
| If so, explain: _____ | | |
| 14. Are you wearing contact lenses? | Yes | No |
| 15. Are you wearing removable dental appliances? | Yes | No |
| 16. What is your chief dental complaint? _____ | | |

Women:

- | | | |
|--|-----|----|
| 17. Are you pregnant? | Yes | No |
| 18. Do you have any problems associated with your menstrual period? | Yes | No |
| 19. Are you nursing? | Yes | No |
| 20. Are you taking birth control pills? | Yes | No |

THIS TWO PAGE FORM MUST BE FILLED OUT ENTIRELY WITH NO QUESTIONS LEFT BLANK. A COMPLETE LIST OF CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) MUST BE PROVIDED.

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Client or Authorized Representative/Legal Guardian

Date

Signature of Dentist

Date

Signature of Anesthesiologist

Date

Notes/updates: _____
